A Guide to TennCare Benefit and Copay Changes
April 1, 2003

The benefits offered by TennCare and the copays required will change on April 1, 2003. This document is intended to serve as a guide to these changes.

All TennCare enrollees will be in one program or the other.
* Those who are Medicaid eligible will be in TennCare Medicaid.
* Those who are not Medicaid eligible will be in TennCare Standard.

1. How do you know who's in one program and who's in the other?

Enrollees who are uncertain about which program they are in can call the TennCare Information Line at 1-800-669-1851 (741-4800 in the Nashville area).

Providers who are uncertain about which program an enrollee is in can check the state's eligibility website, which can be accessed through www.state.tn.us/tenncare.

2. What benefits are available in each program?

A summary of the benefits for each program, and a comparison of these benefits with those offered by TennCare prior to April 1, 2003, is located at: www.state.tn.us/tenncare/benefits.htm

The Medicaid benefits are the same as they were before April 1, 2003, except that the following benefits are **eliminated:**
* Sitter services
* Convalescent care

The following services are available for children through EPSDT but **eliminated for Medicaid adults age 21 and older:**
* Private duty nursing
* Routine eye care
* Cataract glasses or lenses

* Chiropractic services

There will be some **benefit limits for Medicaid adults** that are new. These are as follows:

* Home health services (125 visits per enrollee per calendar year)
* Inpatient and outpatient substance abuse services for adults identified as Severely and/or Persistently Mentally Ill will be limited just as those services are limited for all other adults (10 days detox and $30,000 in lifetime benefits per enrollee)
* Transplant coverage is limited to those procedures which are also covered by Medicare

The TennCare Standard benefits are the same as they were before April 1, 2003, except that the following benefits are **eliminated for TennCare Standard children and adults:**

* Sitter services
* Convalescent care
* Private duty nursing
* Routine eye care, other than an annual eye exam for children
* Cataract glasses or lenses
* EPSDT services for children
* Preventive dental services for children (a package of children's dental benefits will be available for purchase separately)
* Non-emergency transportation
* Chiropractic services
* Certain items of durable medical equipment (DME) in the following areas:
    - Bathtub equipment and supplies
    - Beds/bed equipment
    - Cushions, pads and mattresses
    - Environmental control items
    - Exercise equipment
    - Lifts
    - Lights
    - Nerve stimulators
    - Self-help equipment such as automobile controls and safety bars
    - Speech devices
    - Supports
    - Toilet equipment
    - Wheelchairs
    - Whirlpools

(A list of non-covered DME items is posted on the TennCare website: www.state.tn.us/tenncare.)

There will be some benefit limits that were not present in the prior TennCare program. These **benefit limits apply to TennCare Standard adults and children.**

* Home health services (125 visits per enrollee per calendar year)
* Inpatient and outpatient substance abuse services (10 detox days and $30,000 in lifetime benefits per enrollee)
* Speech therapy (to be covered only as a short-term benefit per condition and limited to 60 days from the original treatment)
* Physical therapy (limited to 60 days from the date therapy begins for any one condition)
* Occupational therapy (limited to 60 days from the date therapy begins for any one condition)
* Transplant coverage (limited to transplants that are also covered by Medicare; members must have been enrolled in TennCare for 6 months before this benefit is available)

3. How are benefit limits counted?

Annual limits are calculated on a **calendar year basis.** That means that enrollees start at "0" on January 1 of each year. Those who enter the program after January 1 will have the same limits that are available to those who were in the program on January 1. There is no "pro-rating" of benefit limits.

Example: Marcus W., who is a Medicaid-eligible adult, has been enrolled in TennCare since 1995. He will have a limit of 125 home health visits during the 2003 calendar year. Jane B. becomes newly Medicaid eligible as an adult in May 2003. She will also have a limit of 125 home health visits during the 2003 calendar year.

Home health services includes the following services provided by a licensed home health agency at a recipient's place of residence and by a physician's orders: part-time or intermittent nursing services; home health aide services provided by a home health agency; medical supplies, equipment, and appliances suitable for use in the home; or physical therapy, occupational therapy, speech pathology or audiology services.

Effective April 1, 2003, home health benefits are limited to 125 visits per enrollee per year for all enrollees except Medicaid-eligible children under age 21 through EPSDT. For Medicaid-eligible adults and all TennCare Standard enrollees, the "begin" date for counting these benefits will be January 1, 2003. Home health agency visits for any purpose are generally considered to be less than 3 hours in duration per visit.

Additional increments of hours provided during the same day are counted as separate visits. However, under no circumstances are part-time or intermittent skilled nursing services covered in excess of 8 hours per day and 35 hours a week, except for Medicaid-eligible children under age 21 through EPSDT. Private duty nursing is not covered under the home health benefit.

Visits are counted toward the 125-visit limit as follows:

* Visits for the purpose of evaluation and/or supervision of staff are considered administrative expenses and are not counted;
* If one person is supervising another in the delivery of a service, only one visit is counted;
* If two or more people provide different categories of service (e.g., home health aide and physical therapy) to the enrollee in the home, each service counts as a visit;
* If a person visits a home two or more times in a day to provide home health services, each visit counts as a separate visit;
* Visits are counted only if payment is made. Visits by personnel to deliver services not covered by TennCare are not counted.

Under certain circumstances, exist for which regular, ongoing home health visits are clinically appropriate and essential to maintain the enrollee in the home. On a case-by-case basis when these circumstances exist, home health visits are not counted against the 125-visit benefit limit. However, the hourly cap on nursing services mentioned above may not be exceeded.

These circumstances are as follows:

1) Services are medically necessary; and
2) Necessary to maintain the least restrictive, most integrated setting; and
3) There is evidence that the enrollee and caregiver(s) are unable to:
    * Care for serious wounds, e.g. severe decubiti; or
    * Administer medication or nourishment or fluids; or
    * Manage ventilator and/or tracheostomy; or
    * Manage tube feeding (gastrostomy or nasogastric); or
    * Manage activities of daily living (ADLs), including bathing, dressing, toileting, transferring, ambulating and feeding; or
    * Accomplish skilled therapeutic interventions (e.g. range-of-motion, swallowing treatment) that, if not provided in sufficient intensity, scope, or duration (beyond the 125 visit limit) would result in the need for more invasive medical treatment or result in a high degree of medical risk of developing more serious, debilitating conditions.

Lifetime limits are calculated over the enrollee's lifetime participation in the TennCare program. All TennCare Medicaid adults, and all TennCare Standard enrollees (adults and children), will have a lifetime maximum of 10 detox days and $30,000 in inpatient and outpatient substance abuse treatment benefits.

4. With respect to services for which there are benefit limits, how will enrollees and providers know how many services the enrollee has used and how many remain?

The enrollee's MCO and BHO will have this information.

5. What happens once an enrollee has hit a benefit limit?

When limits for a particular benefit are reached, the MCO/BHO is no longer required to provide that service to an enrollee. An MCO/BHO may choose to provide benefits beyond the limit if doing so would constitute a "cost effective alternative," but they are not required to do so.

Example: Between January 1, 2004, and May 23, 2004, Janice G. uses 125 home health visits. She is not entitled to any more under TennCare until January 1, 2005. However, her MCO determines that without home health care the only alternative for Janice G. is inpatient hospitalization. Home health care is not as expensive as inpatient hospitalization. The MCO may choose to continue to provide Janice G. with home health care rather than providing her with inpatient hospital services, as long as this choice is medically appropriate for Janice G.

6. How does a family go about purchasing the additional dental package for their TennCare Standard children?

Information about the additional dental package for TennCare Standard children is being sent to eligible families by Doral, the state's Dental Benefits Manager. It will also be posted on the TennCare website at www.state.tn.us/tenncare.

7. What happens when a person who is moving from Medicaid to Standard on April 1, 2003, is using a Medicaid benefit that is not covered by Standard?

Continuity of care policies for these situations have been developed by TennCare.

In general, these policies say that if an individual has a valid authorization for a service on March 31, 2003, that is covered under the "old" TennCare program, he can go ahead and get this service as long as he gets it within 90 days of April 1, 2003.

8. Which benefit package will be available for people who have not completed the redetermination process as of April 1, 2003?

Any demonstration eligible who has not completed the redetermination process as of April 1, 2003, will be enrolled in TennCare Medicaid until such time as the redetermination process is completed.

9. What are the service arrangements for people in the "grandfathered" Medicare/TennCare population as of April 1, 2003?

According to the terms of the new waiver, people who are in the "grandfathered" Medicare/TennCare population will be eligible for the pharmacy benefit only, effective April 1, 2003. We are defining "Medicare" as including both Part A and Part B. These individuals will no longer have an MCO card, effective April 1, 2003. They will have a separate pharmacy card issued by TennCare or TennCare's contractor.

Some of the people in this group may not have signed up for Medicare Part B in the past. They can still sign up for Medicare Part B, although their premiums will be higher than they would have been if they had signed up when they first became Medicare beneficiaries. The next General Enrollment Period for Medicare Part B is January through March 2003, with enrollment being effective on July 1, 2003.

In order to insure that these enrollees do not experience a break in coverage, they will be retained on TennCare through June 30, 2003. They will be expected to sign up for Part B during the Medicare General Enrollment Period, and their TennCare benefits (except for pharmacy) will end on June 30, 2003.

10. Who has copay obligations as of April 1, 2003?

	Adults Age 21 and Older	*Children Under 21*
TennCare Medicaid	No	No
TennCare Standard enrollees with incomes below poverty	Yes (pharmacy only)	Yes (pharmacy only)
TennCare Standard enrollees with incomes at or above poverty	Yes	Yes

A long-term care resident is defined as a Medicaid-eligible person receiving long-term institutional care in a NF or ICF/MR or enrolled in a long-term care Home and Community Based Services waiver program.

11. What are the pharmacy copays?

	TennCare Standard (under 100% poverty)	TennCare Standard (at or above 100% poverty)
Generic, multiple source drugs	$1	$5
Brand name, single source drugs	$3	$15
Brand name, multiple source drugs	$5	$25
Out of pocket maximum for drugs (this ends when the individual and/or family hits their annual out-of-pocket maximum)	$150 per enrollee per month	$150 per enrollee per month

Definitions:

1. Generic, multiple source drugs. A drug which is manufactured without a brand name and which is available from multiple drug companies.

2. Brand name, single source drugs. A drug which is manufactured under a brand name and which is only available from one drug company.

3. Brand name, multiple source drugs. A drug which is manufactured under a brand name but which is available from more than one drug company.

12. How will enrollees know which pharmacy copay amount they are responsible for?

This information will be available from the pharmacist.

13. What are the other copays that are required for TennCare Standard enrollees who are at or above the poverty level?

Doctor visits (except for preventive care)	10 for PCPs, $15 for specialists
Dental visits	$15 per visit
Hospital visits	$100 per admission
Emergency room visits	$25 (waived if admitted)
Annual eye exam for children under 21	$10
Home health visits[1]	$10 per visit
Speech therapy	$10 per visit
Community mental health center visits	$10 per visit

[1] Home health copays are assessed on a daily basis. Individuals having multiple visits in a single day will be charged only one copay.

Psychiatric outpatient services $15 per visit

13. What are the out-of-pocket maximums for TennCare Standard enrollees?

	Individuals	Families
Under 100% poverty	$1,000	$2,000
100% poverty or above	$2,000	$4,000

14. How do enrollees know when they have reached their out-of-pocket maximum?

Each of TennCare's contractors (MCOs, BHOs, DBM, and pharmacy claims processor) will be required to compute copay collections and report them to TennCare on a quarterly basis. This information will be reconciled at TennCare, and enrollees who have paid more than they should have will be refunded their overpayments. Enrollees are also urged to keep track of their copays so that they can report to TennCare when they believe they are reaching their limit.